STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE EMERGENCY MEDICAL SERVICES
152 STATE HOUSE STATION
AUGUSTA, MAINE
04333

PAUL R. LEPAGE
GOVERNOR

JOHN MORRIS
COMMISSIONER

JAY BRADSHAW
DIRECTOR

Medical Direction and Practice Board
April 18, 2012
9:30 am
Minutes

Medical Directors Present – Cormier, Busko, Sholl, Pieh, Goth, Chagrasulis, Randolph
Medical Directors Absent – Klein
MEMS Staff Present – Kenney

Guests – Eric Wellman, Chris Paré, Shawn Evans, Marc Minkler, Joanne Lebrun, John Brady, Ginny Brockway, Mike Senecal, Brian Chamberlain, Kerry Sousa Pomelow, Dustin Nadeau, Mark Boudreau, Cassandra Purington, Don Sheets, Michael Baker,

March 2012 Minutes	Presented - approved as amended	**Motion to Accept: Chagrasulis Seconded: Pieh Approved By: All**
ME EMS Update	ACEP Position for the MDPB – interested candidates to contact Becky Chagrasulis by the end of May (5-30) 1st draft of rules on the website today – comments until May 15th then compiled and reviewed by the Board in June.	
New Device	None Submitted	
Special Circumstanc Protocol	Oxford LVAD Protocol – discussed and reviewed.	
Agitated Patient Pilot Project	Update - Busko/Randolph – Training in Rockland. Ambulances stocked – can begin the program but no patients to date via EMS. Also upcoming training with EMS and Law Enforcement. Busko – no training yet in the Bangor area.	
TEMS Discussion - Follow Up	Off line discussion over the last month – as the IFT dialogue decreases over the upcoming months, will alternate between TEMS and IFT discussions in the hour before the MPDB Have reached out to other stakeholders	
Community Paramedicir	Closing date for the Community Paramedicine Request for Proposals (RFP) is May 1. Legislation enabling the Board of EMS to approve up to 12 pilot programs was signed by Gov. LePage and will go into effect 90 days after the Legislature adjorns.	
Drug Shortages	Update from the Regions – 1) Region 1 – Cormier:change in packaging for Bicarb and Zofran. Minkler:otherwise no shortages other than 2 hospitals being completely out of Benzodiazepines. 2) Region 2 – Chagrasulis/Lebrun – no new word from the hospitals – nice response from hospital pharmacies re: the letter from MEMS and the Regional Offices re: safety 3) Region 3 – Pieh: Appears that the region is doing well but working on communication and collaboration between the hospital pharmacies – using the concept of “weeks supply of medications left”. Most of the hospitals doing well with	

	4-8 weeks of medications left. Only outlier is Maine General with 1-2 weeks of midazolam left but good supplies of diazepam. Working on process of medication sharing between the hospitals. At baseline, most hospitals would only stock 1-2 weeks of supply but due to the medications shortages, the hospitals are in some cases looking to supply up to 4 weeks of medications. Options to obtain medications exist, but these options come at a very high cost. Have been thinking about the question – "What happens when we run out of all benzo's?" 4) Region 4 – Busko: Significant concern at the level of EMMC at the beginning of the month but recently received a large lorazepam stock (but small supplies of diazepam and midazolam exist). 5) Region 5 – Goth: Benzodiazepines continue to be short in Region 5. Have also recognized a shortage of atropine and have needed to move supplies throughout the county. 6) Region 6 – Randolph: Doing well with benzodiazepines but may have to invoke the morphine protocol for one hospital; have discussed other options for status epilepticus. Letter to the Pharmacists urging communication re: safety has been sent. Pieh also drafted a letter urging regular communication for MDPB review and use regionally if necessary. Regional and sub-regional discussions re: medication sharing continues. Goth: discusses the ability to alter the stock within each box. Sholl notes that the decisions regarding the AMOUNT of medication within each drug box largely falls on the shoulders of the regional leadership surrounding the medications agreements. Pieh, Sholl, and Randolph will each work locally and look into non-benzodiazepine options for status epilepticus and present their findings to the group in May. Sholl to review the expiration date potential with NASEMSO	
Discussion: Patients with decision making capacity refusing transport	Feedback from the AAG who has reviewed the language as well as Grey 14. Approves of the language but urged that we consider adding this as clarification to Grey 14. Listed from the December 2011 Minutes: <u>Value of Communication with PCP/Family or POA/Nursing Home Staff/Medical Control</u> A statement to the effect of: "EMS providers should communicate the discovery of decision making capacity and the patient's right to refuse transfer with invested parties. OLMC or the physician ordering transport must be contacted by EMS in this decision making process. It is suggested that the consulted physician discuss directly with the patient." <u>Documentation of DMC and discussion</u> "In all cases of patients who refuse transport, it is essential to document the elements listed above, to include: 1) Calm, competent, sober, and alert (from the C-Spine protocol) – absence of an acute medical/surgical or traumatic process that impairs the patient's capacity 2) Greater than 18 years, emancipated, or contact with guardian 3) What services were offered to the patient 4) Their statement for refusal 5) Statement of risks and patient understanding of risk 6) Patient is aware they may change their mind at any time" Discussion – Significant anxiety about decision-making capacity and the processes around this. Accepted the language (calm, cooperative, sober, alert with no acute medical, surgical, or traumatic process that impairs the patient's capacity) but wanted to interface with the Maine Criminal Justice Committee to discuss the education behind this language. Also, interested in process mapping what happens with these patients – ie: contact OLMC, contact Law Enforcement, but what to do if Law Enforcement disagrees with the provider and OLMC?	**Interface with the Maine Criminal Justice Committee to discuss LE education regarding decision making capacity (B Chamberlain)** **Also, process map what happens with these patients – (T Pieh)**
Revisit – Protocol	Protocol process this cycle took 18 months. Began discussing in May the MDPB process for protocol review as well as the proper cycle length for protocol review. In June, the MDPB, un	**Regional Directors/Medica**

Review Process Discussion	the guidance of the Education Committee, opted to hold on major changes to the protocol review process in lieu of reviewing the educational impact and the educational process for thi protocol update (recall, the Education Committee embarked on a novel educational process that included involvement of the regional offices, regional medical directors and a new on line educational process through MEMSEd.org). Feedback from the Educational Committee (via Dan Batsie) has been very supportive about t educational process – and the combination of regional educational efforts supported by the regional directors and regional medial directors as well as MEMSEd.org appears to have worked very well (as of February, over 1200 providers – 20% - updated via the MEMSEd.org website). Based on this experience, the MDPB should consider their interest in altering cycle length for protocol updates. 1) Should the protocol update cycle be altered (prior discussions suggested 2 year cycl length) a. Benefits – fewer changes over time, less work – spread out over longer perio of time, greater ability to change the protocols as needed, could be beneficia to have greater education about the protocols and with the MEMSEd.org option, the impact on individual providers or services could be minimized b. Downside – Could occupy a significant amount of the MDPB time, will have a workload impact on the MDPB, Education Committee, Operations, and MEM Staff c. Discussion – 2) When does protocol review process begin? a. Recall, the process took 18 months prior. Will likely take LESS time as the MDPB has done significant amount of work around the protocols recently. 3) Review Protocol Assignments – a. Purple/Brown/Grey/Black – Matt b. Blue – Tim c. Red – Marlene d. Green – Jonnathan e. Yellow – Peter f. Gold – Whit g. Pink - Becky	**Directors to poll their constituencies re: thoughts on the process and changing to a 2 year cycle**

Old Business

MEMS Education	CBO and CEH work continues
MEMS Operations	Supplement on May 18th, Awards on May 23rd at 11 am in the Hall of Flags
MEMS QI	
IFT Subcommitt	Discussed updates to the Medical Direction Manual Reviewed Progress to date Discussed work plan moving forward….

Next Meetings – May 16, 2012

MDPB – 9:30 – 12:30
QI – 1:00 – 3:00